SHELLEY MANOR DENTAL

New Patient Registration

All patient information will be treated confidentially, and is solely for the use of the dental practice.

Tital: ____ Surname: ______________________________ First Name(s): ___________________________

Date of Birth: ______________________________ Occupation: _______________________ ______

Home Address: ____

Postcode: ______________________________ Email address: ____________________________

Home Phone No. _________________________ Mobile No. ______________________________

Emergency Contact Name: _________________________ Phone: ___________________________________

- Do you give Shelley Manor Dental permission to send you appointment confirmation messages and appointment reminders using the given mobile number and email address? **Yes / No**
- If you do not possess a mobile telephone, do you give Shelley Manor Dental permission to send you SMS messages via your landline telephone? **Yes / No**

How did you hear about us at Shelley Manor Dental? ____

If you were recommended to us by another patient, what is their name? ___________________________

Dental History

1. Name of last dentist? ____________________________ 2. Approx. date of last visit:_______________

3. Do you have dental / gum pain or a dental problem at present? Yes/No

If yes, please give details: ____

____

4. Have you ever experienced excessive bleeding or bruising from dental/hygiene treatment? Yes/No

5. Do you become anxious or uncomfortable when you are having dental treatment? Yes/No

By signing this form I consent to a Dental Examination, Photos & X-rays taken of my face and mouth.

Signed: Patient/Parent/Guardian: ______________________________ Date: _____________

If you're unable to attend your appointment, please give us a minimum of 24 hours notice so your slot can be allocated to another patient. Otherwise a 'failure to attend' fee will be charged to cover costs.

Confidential Medical History Questionnaire

This provides the dentist with important information required for your dental treatment.

Name: ____________________________________ Date of Birth: ___________________________

Name of your GP (medical doctor): ___________________ GP Surgery Name & Tel: ____________________

Medical History

1. Are you receiving any medical treatment at the present time? Yes / No
   Details:
2. Are you currently taking any medication? Yes / No
   Details:
3. Do you have any allergies eg. latex, nickel, antibiotics, local anesthetics, other tablets or drugs? Yes / No
   Details:
4. Do you or have you ever had any of the following? If so, please tick as appropriate.

- ☐ Rheumatic Fever
- ☐ Heart Trouble
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Arthritis
- ☐ Hepatitis - Specify type A, B, C
- ☐ Bronchitis or Chest Problems
- ☐ Severe Headaches
- ☐ Epilepsy
- ☐ Anemia
- ☐ Diabetes
- ☐ Kidney Trouble
- ☐ Gastric Problems
- ☐ Cold Sores
- ☐ Depressive Illness
- ☐ Drug Dependence

5. Have you had any prosthetic surgery? e.g. Heart Valve or Hip Replacement Yes /No
   Details:
6. Are you pregnant? If so, how many months: ___________ Yes / No
7. Are you HIV positive, or at risk to HIV exposure? Yes / No

8. Do you smoke? Yes / No

By signing this form I consent to a Dental Examination, Photos & X-rays taken of my face and mouth.

Signed: Patient/Parent/Guardian ______________________________________ Date: ____________

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Occlusal Screening Questionnaire

Please take a few moments to answer the following questions, which will allow our dental team to provide care & advice based on your concerns and individual needs. Your answers are for our records only & will be treated as confidential.

Name:________________________

1. Do you clench or grind your teeth during the day? Y / N

If yes, please explain

2. Have you been made aware of clenching or grinding during your sleep? Y / N

3. Do you have chronic headaches, neck or shoulder pain? Y / N

4. Are your teeth or jaws tired when you wake up in the morning? Y / N

5. Have you ever experienced pain in your jaw joints, the sides of your face or ears? Y / N

6. Have your jaws ever clicked or popped when you open your mouth? Y / N

7. Have you ever experienced difficulty moving your jaw or opening your mouth? Y / N

8. Do you chew on only one side of your mouth? Y/ N

If you're unable to attend your appointment, please give us a minimum of 24 hours notice so your slot can be allocated to another patient. Otherwise a 'failure to attend' fee will be charged to cover costs.